

**SENIOR AND LONG TERM CARE DIVISION  
DIRECT- CARE WORKER SURVEY  
FOR COMMUNITY BASED WORKERS**

The following health care survey is intended to gather information to be used by the Department in meeting SB 206 requirements to study the feasibility of providing funding for employees health insurance.

Please take a few minutes to complete this survey, and you may be able to use your employer's fax machine or return it to your employer for mailing back to the Department.

A. Do you currently have health insurance for yourself? (check one)

1. ☐ Yes
2. ☐ No

B. If yes, do you have coverage for your family? (check one)

1. ☐ No
2. ☐ Yes, my spouse only
3. ☐ Yes, my spouse and children
4. ☐ Yes, my children only

C. If you do not have health insurance, please indicate the reason why. (check one)

1. ☐ My employer does not offer health insurance
2. ☐ The health insurance my employer does offer is too expensive.
3. ☐ I do not qualify for my employer's health insurance

D. If you do have health insurance, what is the source of your coverage? (check one)

1. ☐ I am insured through my employer.
2. ☐ I am insured through my spouse's employer.
3. ☐ I am insured through my parent's insurance
4. ☐ I am enrolled in the Medicaid program.
5. ☐ I have Medicare
6. ☐ I have IHS (Indian Health Service)
7. ☐ I have Tri-Care
8. ☐ Other Health Insurance. Please describe: \_\_\_\_\_

E. How old are you? \_\_\_\_\_

F. Gender (check one)

1. ☐ Female
2. ☐ Male

G. Are you married? (check one);

1. ☐ Yes
2. ☐ No

H. How many children do you have who are under the age of 21? \_\_\_\_\_

I. How many of your children are currently enrolled in the Medicaid program? \_\_\_\_\_

J. How many of your children are currently enrolled in the Children's Health Insurance Program (CHIP)? \_\_\_\_\_ (For information about enrolling in CHIP, please call 1-877-543-7669)

K. Have you ever been or are you currently enrolled in the Temporary Assistance for Needy Families (TANF) program (check one)?

1. ☐ currently enrolled
2. ☐ Yes – have been enrolled in TANF in the past
3. ☐ No – have not been enrolled in TANF

L. If your employer offered health insurance at no cost to you, would you participate in the coverage (check one)?

1. ☐ Yes
2. ☐ No If not, why: \_\_\_\_\_

M. If your employer offered insurance and you were required to pay a portion of the monthly premium, how much would be willing to pay each month? (please check those that apply)

Amount Willing to Pay	Self	Self & Spouse	Self & Children	Family Coverage
\$ 1.00 - \$10.00 per month				
\$11.00 - \$20.00 per month				
\$21.00 - \$30.00 per month				
\$31.00 - \$40.00 per month				
\$41.00 - \$50.00 per month				
\$51.00 – \$100.00 per month				
\$101.00 – \$150.00 per month				
\$151.00 - \$200.00 per month				
more than \$200.00 per month				

N. If your employer offered insurance would you be interested in covering your spouse and children (check one)?

1. ☐ No
2. ☐ Yes, my spouse only
3. ☐ Yes, my spouse and children
4. ☐ Yes, my children only

- O. What is your total annual family income?
1. \_\_\_\_\_ Under \$24,000.00 per year
  2. \_\_\_\_\_ \$24,001.00 to 35,000.00 per year
  3. \_\_\_\_\_ \$35,001.00 – 50,000.00 per year
  4. \_\_\_\_\_ \$50,001.00 or more per year
- P. What is the name of the agency where you work? \_\_\_\_\_
- Q. How many hours per week do you work (average) for this employer?
1. \_\_\_\_\_ 40 or more
  2. \_\_\_\_\_ 30 -39
  3. \_\_\_\_\_ 20-29
  4. \_\_\_\_\_ 10 to 20
  5. \_\_\_\_\_ 1 to 10
- R. How long have you worked for this employer providing direct care services to consumers? \_\_\_\_\_
- S. What is your job title:
- |                             |       |
|-----------------------------|-------|
| Habilitation Aide           | _____ |
| Homemaker                   | _____ |
| Respite Care                | _____ |
| Specially Trained Attendant | _____ |
| LPN                         | _____ |
| RN                          | _____ |
| Home Health/Hospice Aide    | _____ |
| Therapy (OT, ST,PT)         | _____ |
| Other: Identify             | _____ |
- T. If you are now working part-time as a direct care worker and you had to work an average of 20 or more hours per week in order to be eligible for health insurance through your employer, would you try to work more hours so you could get the health insurance? (please check one)
1. Yes, I would try to work 20 or more hours per week so I could get health insurance \_\_\_\_\_
  2. No, I won't be able to work 20 or more hours per week \_\_\_\_\_
  3. I already work more than 20 hours per week most of the time. \_\_\_\_\_
- U. If you are now working part-time as a direct care worker and you had to work an average of 30 or more hours per week in order to be eligible for health insurance through your employer, would you try to work more hours so you could get the health insurance? (please check one)
1. Yes, I would try to work 30 or more hours per week so I could get health insurance \_\_\_\_\_
  2. No, I won't be able to work 30 or more hours per week \_\_\_\_\_
  3. I already work more than 30 hours per week most of the time. \_\_\_\_\_

V. How important do you think it is that the employers that provide Medicaid direct care services be able to offer health insurance to their employees such as you and the others that provide these direct care services. (please check one)

1. Extremely important \_\_\_\_\_
2. Very important \_\_\_\_\_
3. Somewhat important \_\_\_\_\_
4. Not that important \_\_\_\_\_
5. Not important at all \_\_\_\_\_

W. Comment section (feel free to write in your thoughts or comments on this Healthcare Issue for Direct Care Workers):

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THANK YOU FOR YOUR TIME IN COMPLETING THIS SURVEY

Remember to return this survey by June 23, 2008!

Please fax your survey responses to 444-7743;

or return it to your employer for mailing back to the Department;

or by email to [rhoman@mt.gov](mailto:rhoman@mt.gov)

or mail to: DPHHS  
SLTC  
Attn: Robin Homan  
PO Box 4210  
Helena, MT 59604

Any questions should be directed to Robin Homan at 444-4131.